

# FROM TRAGEDY TO 'CRIP' TO HUMAN: THE NEED FOR MULTIPLE UNDERSTANDINGS OF DISABILITY IN PSYCHOTHERAPY

## INCAPACITÉ ET PSYCHOLOGIE

Kaley Roosen

### Abstract

Individuals with disabilities have been largely ignored from research and training in the field of Psychology. Historically, when disability is discussed in psychotherapy theory, it is often pathologized as a condition that contributes to a maladaptive personality and poor societal functioning. The following research paper proposes a new understanding of disability in the field of Psychology through the introduction of a disability-affirmative model. Through understanding disability expansively as an extension of the human condition, a distinct minority group, a rich and valued culture, and as a bodily experience, Psychology can best contribute to the diverse lives of those with disabilities. Furthermore, by adopting a more flexible and positive view of disability, Psychology will be more open to the innovative and valued ideas presented both from professionals with disabilities and individuals within Critical Disability Studies in research, practice, and training.

*Key Words: disability, affirmative, psychotherapy, models, Psychology*

### Résumé

Les personnes ayant des incapacités ont été largement ignorées de la recherche et de la formation dans la discipline de la psychologie. La théorie de la psychothérapie a historiquement considéré l'incapacité comme étant une condition pathologique contribuant à une personnalité désadaptée et à un fonctionnement social peu développé. Cet article propose une nouvelle compréhension de l'incapacité dans la discipline de la psychologie par l'introduction d'un modèle représentant l'incapacité positivement. En comprenant l'incapacité comme étant partie prenante de la condition humaine, comme la caractéristique propre à un groupe minoritaire ainsi que comme une culture riche et valorisée, la psychologie pourrait mieux saisir la complexité des vies des personnes ayant des incapacités. De plus, en adoptant un point de vue plus flexible et positif sur l'incapacité, il est espéré que la discipline de la psychologie sera plus ouverte à l'innovation et valorisera les idées présentées par des professionnels ayant des incapacités et ceux provenant de la discipline des Études sur l'incapacité concernant la recherche, la pratique et la formation.

*Mots-clés: incapacité, psychothérapie, Psychologie, modèle, théorie, valorisation*

### Introduction

Despite the development of accommodations and efforts at inclusion in present social contexts, there persists the assumption that people with disabilities have a significantly lower quality of life than nondisabled people have. Perhaps the most distressing examples of this negative perception are comments like the following: “Maybe it would have been easier if they were never born”, or, “I would never want to live like that”. As a person living with a disability and as a clinical Psychology graduate student, I find these common opinions and attitudes to be greatly upsetting. Here I am, in a field where we are supposed to help individuals reach their full human potential for growth emotionally, physically, interpersonally, and spiritually; yet, the institution of Psychology and its history fall prey to the same beliefs that the general population tends to hold.

In 2001, the World Health Organization (WHO), specifically the International Classification of Functioning, Disability and Health (ICF), which guides the understanding of disability for the American Psychological Association (APA), defined disability “as the outcome of the interaction between a person with an impairment and the environmental and attitudinal barriers he/she may face”. This definition of disability has been unanimously accepted in 191 countries as the conceptualization or understanding of disability. Although its acknowledgement of environmental barriers toward disablement is praiseworthy, it seems this understanding of disability only shifts the blame of the ‘problem’ of disability from personal to environmental conditions (Romanach & Laboto, 2005). How can therapists trained in this atmosphere ever view disability as anything other than a problem or someone with disabilities as anyone other than individuals incapable of fully reaching

their human potential given their insufferable condition and impairments (Shakespeare, 1999)?

### Purpose

The aim of this paper is to present a revised model for understanding disability in the field of psychotherapy. This model, the disability-affirmative model, presents a more positive and eclectic definition of disability. To begin, I will critically examine the involvement of psychotherapy in disability to date. I will explore the various models of disability, both historically and in modern times, in the hopes of exposing how a thorough understanding of each model is essential for a successful integration of disability into psychotherapy. In fact, I propose that a narrow definition of disability is the main problem that has coloured psychotherapy's current negative views of persons with disabilities. Finally, I will explore the importance of adopting a positive and flexible view of disability, and I will touch on how we can integrate this model pragmatically into the practice, research, and training in the psychotherapy field. In my opinion, through this model, a more inclusive and hopeful environment will develop for individuals with disabilities, for psychotherapy could then come to be enriched thanks to the inclusion of a unique and empowered minority group.

### Evaluation of Psychotherapy Services for Persons with Disabilities: Missing Perspective

In a critical paper on linking community Psychology with Disability Studies, Goodley and Lawthom (2005) describe mainstream Psychology as a "pathologising,

voyeuristic, individualizing, impairment-obsessed discipline that has contributed to the exclusion of people with impairments” (p. 136). A sharp critique of Psychology by any measure, the authors proceed to describe Psychology as a manifestation of societal culture and its political agendas. If we examine the basic tenets of Psychology, it is clear where the disjoint occurs. According to Linton and Daugherty (1999), Psychology studies the abnormal in an attempt to legitimize empirical research that labels disabled people as ‘statistical outliers’, and psychological interventions focus on the individual level, not the sociopolitical. In other words, psychological theory and its basic research practices contribute to the oppression and exclusion of individuals with disabilities. Although this is an important issue that should be further examined, the focus of this paper is more on how the models of understanding disability in mainstream psychotherapies translate to the evaluation of services for people with disabilities. Therefore, I will now explore how psychotherapy services have been received from the disabled client’s perspective.

In a recent review examining the need for, and access to, psychotherapy for individuals with disabilities, disabled people found mainstream therapists, such as psychologists, to have little understanding of disability. However, nearly everyone interviewed in this study indicated they could have benefitted greatly from access to support and emotional counselling (McKenzie, 1992). One goal of this review is to understand how important it is that we psychotherapists are more aware of disability.

The first critical aspect of psychotherapy for individuals with disabilities, as illustrated by the study above, is that therapists are ignorant to the “special” needs of disabled people. Often, clients report that their therapists overemphasize their physical

impairments, when often these clients are entering therapy due to stresses over their lack of control over their physical and social environments or stresses that have nothing to do with their disabilities (Oliver, 1996). Further, the individuals in Oliver's study indicated a frustration with therapists treating disability as a homogeneous group. For example, in Psychology, we often see an over-reliance of stage theories to explain how an individual with a disability responds to his or her disability psychologically (e.g., Livneh, 1986).

There has been little research looking at therapist attitudes toward disability, but the few that have been done show that therapists fall victim to the same negative attitudes as the general population. As an illustration, consider Parkinson's (2006) study on counsellors in training. One therapist remarked:

I found it very hard to see the person as someone in their own right. I kept looking at their wheelchairs or their glasses. It took me a while to see them just as a person who watched the same TV programs as me and laughed at the same jokes. I feel sad about that (p. 99).

Further, it is becoming clear that persons with disabilities are finding their own voice, and they are not willing to allow professionals to tell them what is best for them (Finkelstein & French, 1993). In order for this empowered sense of control to coexist with a therapist the client feels 'gets' disability issues, it will take education and awareness on the part of the therapist. However, as Reeve (2002) comments, many therapists mistakenly hold the unobtainable belief that since they accept all people, they do not need disability sensitivity training, despite literature by individuals with disabilities reporting that they feel misunderstood and even oppressed. This is an assumption that therapists must challenge if we are ever to change the culture of disability awareness in psychotherapy.

Although there has not been much research on this area, it is assumed there are multiple barriers existing that can exclude persons with disabilities from participating in psychotherapy. Reeve (2002) analyzes the presence of oppression within the counselling room and comments on how disabled people have less access to counselling overall compared with non-disabled individuals. Structurally, financially, comprehensively, and attitudinally, a therapist's private services can become filled with obstacles preventing individuals with disabilities from accessing their services. Research in this area is greatly needed in order to break down exactly why people with disabilities are not using the services and if they are, how they would evaluate these services.

The bottom line is that psychotherapy is not delivering its services to meet the needs of individuals with disabilities. The reasons for this deficit in the services are numerous, including lack of disability sensitivity training for therapists, a negative and prejudiced view of disabled people from psychological and medical research, lack of representation of disabled professionals, as well as communicative and structural barriers that exclude both disabled clients and disabled professionals (Reeve, 2002). However, I believe the most vital reason for this inability for psychotherapy to measure up is the lack of acknowledgement that disability is a societal problem rather than a problem within the individual. One of the very few studies on disabled individual's views of psychotherapy found that disabled people felt misunderstood (McKenzie, 1992). In other words, clients felt that therapists did not understand the unique issues that disability brought forth. Therefore, I believe that changing the mindset of therapists such that they have in mind a

comprehensive, flexible, positive definition of disability is the solution to opening those channels of communication.

Further, most members of society adopt one or maybe two models of what disability means (Olkin, 2001). Our society, and Psychology in general, are historically and currently entrenched in the medical and individualistic views of disability (Shakespeare, 1999). Therefore, this next section of the paper will focus on what these ‘other’ understandings of disability are and how our current models of understanding disability can still be used to enhance our knowledge of, and attitude toward, disability.

### The Models of Disability

The various models of disability are not simply abstract concepts. Rather, they represent a way of understanding how a group of people fit into the world (Neisser, 1967). To simplify matters, if we think of an individual’s schema, or the map by which she or he perceives the world, as an organization of all her or his assumptions, beliefs, and ideas about disability developed from an early stage, one can see how a particular schema or understanding of disability will guide their thoughts and actions toward this group of people (Shakespeare, 1999). For example, if a person was taught that disability was a medical impairment that strikes individuals at random and causes them great suffering, then this is how they would view all disabled people. In summary, if most individuals schematize or understand disability under a certain model, with its own beliefs and assumptions, then this viewpoint has a way of guiding our behaviour toward this group

(Neisser, 1967). This, as we have seen above, is assumed to have implications on the treatment of disabled individuals within psychotherapy.

I will now attempt to summarize each model used in order to understand disability in the hopes of encouraging a broader framework of understanding and a more positive model. Further, I will attempt to abstract both the positive, negative, and neutral aspects of each model. Given that it is not just nondisabled people, but also persons with disabilities who create internal schemas of disability, it is imperative for a therapist to understand clients' conceptualizations of their disabilities.

*Moral Model: "The Chosen"*

The moral or religious definition of disability is historically the first understanding of disability. During the Pre-Enlightenment era, in Judea-Christian culture, differences in individuals were understood according to Biblical references. Disability was seen as something God had chosen an individual to bear or the disabled person was seen as being punished for his or her sins (Olkin, 2001). Persons with disabilities living during this time would have been treated with pity, shame, and exclusion.

Although this style of understanding disability is often considered outdated and irrelevant, the reality is that this model is still widely prevalent today. The overarching message presented in the moral model of disability is that disability is a personal tragedy in which a person is suffering and we, as mere mortals, could never fully understand the reason for this suffering, but take comfort in recognizing it is God's will (Lonsdale, 1990). Popular sayings, such as, "God wouldn't have given you this cross to bear unless He knew



you could handle it” reveal this type of conceptualization. As therapists, understanding disability as a personal tragedy can be dangerous for the therapeutic alliance. For example, in Parkinson’s (2006) study on counsellors’ attitudes toward disabled people, it was found that 75% of therapists view disability as a personal tragedy. Defining an individual’s life as tragic tends to elicit feelings of pity from the therapist, which only alienates and isolates the client (Shakespeare, 2008).

Although solely viewing a person with a disability through a moral model can be damaging and demeaning, this does not justify the exclusion of this model altogether. Qualitative research and autobiographies of persons with disabilities understanding their ‘tragedy’ reveal that many individuals ascribe a deeper meaning to their disability. As an example, consider a quote from a study examining how a spiritual sense meaning for women with multiple sclerosis actually contributed to a higher reported quality of life: “God has allowed me to have MS and he doesn’t make mistakes; the strong are chosen to cope with the disease” (Pakenham, 2008, p. 99). Further, some individuals with disabilities have turned to religion and this model as a way to find community, peace, and satisfaction in their lives. Consider a recent study by Yohannes, Koenig, Baldwin, and Connolly (2008), which found that religious attendance was associated with positive general health perception and less severe illness symptoms. Therefore, it is important for any therapist to be open to a more spiritual understanding of disability, especially if one’s client adopts this viewpoint and if it can help an individual in the long run.

*Medical Model: “The Impaired”*

The medical model of disability emerged historically during the eighteenth century, which marked the Age of Enlightenment and the beginning of the Industrial Revolution. Perhaps the most widely known and accepted view of disability, here disability is viewed in medical terms. A person with a disability has a medical error within their physiology or psychology due to a number of factors, such as environment, genetics, or lifestyle, all or any of which prevents them from being fully functional human beings (Olkin, 2001). The best way society can help individuals with disabilities in this case is through the use of science and medicine in order to cure the person of this mistake, or ease the physiological or psychological pain if science cannot cure the error. It was during the emergence of the medical model that the term *cripple* was put away and the term *disability* was introduced. Disability was a term used to describe those individuals who were unable to contribute to the productivity ignited by the Industrial Age.

The messages about disabled people that the medical model encourages are the following: disability is a mistake, there is a difference between being disabled and not disabled and it is better to be not disabled, and a disabled person is not a fully functioning individual. The implications for this narrow type of understanding of disability are devastating in psychotherapy. To view an individual as distinct from other healthy human beings creates an empathetic barrier between the disabled person and the therapist. Further, it encourages the therapist to take control of this disabled person's life, given that the therapist is the expert. As an illustration of this type of thinking in psychotherapy, consider Freud's views of disability because he was extremely influential in the foundational origins of psychotherapy and was a medical doctor by profession. In Freud's *On Narcissism*

(1920), he describes individuals with disabilities as incapable of being psychoanalyzed due to these their loss, causing their libido to withdraw into their ego and away from objects. As a more recent example, Fow (1998) promotes the use of supportive psychotherapy for persons with physical disability: “the individual in supportive therapy is considered incapable of working with these techniques [unconscious material used to inform insight], most often because of an intolerance of the anxiety which accompanies them” (p. 1). Here, the person with a disability is seen as dysfunctional physically, mentally, and emotionally, and incapable of having unconscious insight and participating in basic psychoanalysis. It is this type of human separation of persons with disabilities that causes great concern for psychotherapy.

Although the medical model has been highly criticized for its oppressive and dualistic practices, it does present some merit in working with persons with disabilities. The medical model is beneficial for dealing with medical issues, and the reality is that many people with a disability experience secondary health complications because of their disability. Medical science can help alleviate pain. Pain has been shown to reduce quality of life in individuals with disabilities significantly, influencing their mental health, their employment status, and their social functioning (Mancin, Stecklov, & Stewart, 2003). No other understanding of disability would be able to help these individuals in bodily pain. Further, some client’s report taking comfort in knowing there is a medical cause to their disorder (Pakenham, 2008). It is important that therapists are medically aware of both the dangers and the advantages of understanding disability.

*Social Model: “The Oppressed”*

The social model was presented in strong objection to the medical model. Emerging from the disability rights movement during the 1960s, this model of understanding disability existed in stark contrast with the idea that disability was a personal problem. Here, disability is seen as a social problem in that the person with the disability is not deficient, but rather the societal environment that creates barriers to exclude individuals who get around the world differently, is the problem. Individuals with disabilities are viewed as members of a selective minority group subject to discrimination found in an ableist society that promotes the view that nondisabled people are superior (Barnes, Mercer, & Shakespeare, 1999).

The social model has gained significant political advancements for those with disabilities (Oliver, 1996) and has brought disability issues to the forefront when discussing social change (Beckett & Wrighton, 2000). Persons with disabilities cannot be discriminated against, excluded from participation, or denied resources such as, shelter, employment, public service buildings, and education. This model shifts the focus from oppression to empowerment in the life of an individual with a disability. Instead of believing one’s disability is some sort of personal deficiency, individuals can take comfort in the fact that it is not selfish to demand equal treatment and that they are not alone in this experience.

Although this new way of understanding disability was viewed as a positive change, there still exists a threat to misunderstanding persons with disabilities in psychotherapy. As Dewsbury, Clarke, Randall, Rouncefield, and Sommerville (2004) argue

in their critical examination of the social model, this model radically reduces the total experience of an individual with a disability as that of an oppressed minority and further creates isolation by its separation of two groups, in which one can never truly understand the needs of others. This means that if a psychotherapist without a disability was seeing a client with a disability, they can never fully understand their oppressive experience as the therapist is a member of the outside group that is partially to blame. Further, this model also discounts the very real experience of secondary health conditions, functional impairments, and pain that many individuals with disabilities experience (Barnes, Mercer, & Shakespeare, 1999). Despite the fact that the social model has been instrumental in gaining equal rights for persons with disabilities, there is a risk of over-reliance on this conceptualization to the point where it can further oppress the disabled person's value and existence (Crow, 1996).

*Humanistic Model: "The Human Being"*

Although not an official definition or model for understanding disability, I believe the humanistic model of understanding disability can be found in research, practice, education, and among everyday conversations. The humanistic model of disability views disability as part of the human condition. Here, there is no separation between disabled and nondisabled; rather, people's abilities exist along a continuum and we are all disabled in one way or another. Further, client-centered theory in regards to psychotherapy and physical rehabilitation focuses on whatever issues the client wants to focus on.

In Disability Studies literature, we can find such a conceptualization of disability in the views of theorists trying to eliminate the dualistic compartmentalization of disabled versus nondisabled. In Patston (2007a, 2007b), a new term is presented known as functional diversity. Here, the author suggests eliminating the distinction between disabled altogether and instead seeing people on a continuum of functionality. This new way of understanding disability would place disability in a positive light, rather than continuing to stigmatize the identity characteristic. Further, this would encourage more client participation in their psychotherapy or physical therapy given only the client would know what functionality they would value and want to improve or maintain. Finally, the person with a disability would not have to feel different, impaired, or like a mistake if they truly conceptualized disability in this sense.

In theory, a humanistic style of understanding disability would be the ultimate solution. However, in reality, this conceptualization does not work. First of all, not acknowledging a person's disability can be extremely damaging. A person's identity and existence may be greatly influenced by his or her disability (Shakespeare, 1999). To ignore this part of their existence because one wants to see people along a continuum of abilities can make an individual feel misunderstood. Another reason why the humanistic model could not be used on its own is simply that therapists are people too. Therapists have grown up in an ableist society in which the rights of individuals with disabilities are often not addressed (Corker, 1995). Therefore, it is essential that persons with disabilities protect our minority status and continue to push for social change until a day comes when people can see disability as part of the human condition.

*Cultural Model: “The Crips”*

Individuals with disabilities, although an extremely diverse group of individuals, also exist within a cultural group of shared ideals, interests, and beliefs. Just like any cultural group, persons with disabilities have their own language style, for example, using ‘crip-talk’, art, literature, clothing, and movies. If there ever were a place to be proud to have a disability, this group of individuals is that place. As a therapist, having knowledge of this cultural identity and identifying with the disability community can help you to understand your client. Further, a client with no knowledge of disability culture may wish to learn more about it. The ultimate benefit for a client to be part of such a proud culture is for them to have a larger sense of community and to experience the positive aspects of living with a disability.

As with every model of understanding disability, disability culture could have a particularly damaging effect if taken to the extreme. Creating a selective community of individuals who are already stigmatized in society could create a greater sense of stigmatization and oppression (Galvin, 2003). Also, if one sees the disability community as a unitary group, there is a risk of assuming homogeneity, despite the fact that the disability community covers a vast range of disabilities and experiences (Shakespeare, 1999). Finally, by creating a subgroup of individuals with disabilities, there can also be a further sub-grouping within the disability community of individuals based on race, gender, or sexual orientation (Dewsbury et al., 2004). As a therapist, it is important for you to be educated on disability culture and share this education when you are called upon to do so.

However, like every model of disability, subscribing to this viewpoint and forcing it onto others could have potentially damaging effects (Reeve, 2002). If people with disabilities have no positive thoughts about their disabilities and wish to discuss this in therapy, they may feel invalidated by a more positive disability framework.

### *Integration and Summary of Definition of Disability*

Each model of understanding disability has a unique history and idea of what it means to be a disabled individual. Each of us understands disability differently depending on which model was taught to us and how we integrate these ideals into our overall understanding of how the world functions (Neisser, 1967). Further, individuals living with disabilities also were taught specific models of disability and have integrated their own understanding of their disability and others' disabilities based into their experiences and ideals (Shakespeare, 1999). As I have shown with each of the models of disability, one model cannot explain disability on its own (Shakespeare, 1996). Each model has its unique contribution to the entire understanding of disability, and the only way to avoid stigmatizing, invalidating, dismissing, and pitying individuals with disabilities in psychotherapy is to combine all of these models and challenge your own ideals and assumptions about disability (Olkin, 2001; Parkinson, 2006). As a comprehensive method to combine all of these models in the hopes of improving the integration of disability into psychotherapy, this paper presents a disability-affirmative model of understanding disability and disabled persons.



### Disability-Affirmative Model

The term *disability-affirmation* in Psychology was developed in as a type of psychotherapy and a tool for guiding therapists working with disabled clients (Swain & French, 2000). The core assumption that underlies the disability-affirmative model in psychotherapy states that “a client’s disability should be taken as information enhancing the case conceptualization in a way that it neither underestimates nor overinflates the importance of the disability” (Olkin, 2001, p. 355). Here, there are four areas of importance when understanding disability and working with disabled clients: 1) understanding models of disability, 2) understanding disability can influence development, 3) understanding and developing a positive view of disability culture and community, and 4) understanding both the psychological and social impacts individuals with disabilities. Under a disability-affirmative model, disability is viewed as neither damaging nor pathological, but rather, is seen as having value or worth. Further, Olkin (2001) argues that a key component of disability-affirmation is understanding the client’s own model of disability. According to the disability-affirmative model, disability is recognized as an important part of an individual’s identity; however, affirming disability is also accepting that it is clients who decide how big a part their definition of disability is in comparison with other parts of themselves, and which model of disability they use in order to understand themselves and others. Part of being a therapist who understands disability according to the disability-affirmative model is being flexible enough to accept the client’s own understanding of disability and being able to bring out the positive aspects of their disability, no matter which ideals they subscribe to. Therefore, there is an overarching need for therapists to

understand disability from multiple models. Further, having disability-affirmative therapy also involves removing any barriers for persons with disabilities to access services. In that sense, the model requires a lot of the therapist in terms of education, acceptance, and evaluating their own preconceived notions of disability. However, this may be the only way to allow persons with disabilities to feel that they can go use a ‘regular’ psychotherapy services without experiencing barriers, attitude, ignorance, or misunderstanding.

### *Assumptions and Limitations*

The disability-affirmative model presented makes a few important assumptions that will be addressed here. The disability-affirmative model was extracted from the social model of disability, in which disability is understood as a social construction; it was, however, expanded upon to include other models of disability given that the social model has been criticized for not being able to fully capture the unique experience of disability (Shakespeare, 1996). The disability-affirmative model, as a hybrid of psychological theory and Critical Disability Studies theory, assumes that individuals with disabilities are fully capable of reaching their full human potential, no matter what that potential may be (Olkin, 2001). This flexibility, inherent in the model’s humanistic emphasis on the disabled client’s ability to choose, is essential to removing the power differential apparent in most traditional psychotherapy models. However, the model also acknowledges that there are important cultural, political, and social forces at work impacting an individual’s life choices. Ultimately, a core assumption of the disability-affirmative model presented is that, given the proper therapeutic conditions (see Rogers, 1957 for a review) and special

acknowledgement of sociopolitical forces impacting disabled individuals (Olkin, 2001), people will choose the path that is right for them, and it is up to the therapist to support the client's personal growth.

Despite the potential benefits for the disability community in adapting to a disability-affirmative model, there are several limitations of this model that warrant attention. First of all, the model does not challenge power relations directly (Erevelles, 1997). The model is presented as an alternative method to understanding disability for psychotherapists in the hopes of challenging negative attitudes, but the issue of oppression of disabled people in Psychology is a much larger issue that needs to be addressed. As Lawthom (2005) discusses, Psychology as a discipline needs to step away from its medical lens of comprehension and acknowledge the sociopolitical factors at work. Also, there is a lack of research in the field of psychotherapy exploring how persons with disabilities evaluate an appropriate type of psychotherapy. The claims I present in the paper are given in the spirit that a humanistic model, in which the disabled client has the ultimate power in a therapeutic relationship while acknowledging sociopolitical forces, is the best approach. However, this claim remains to be evaluated by individuals in the disability community, as well as practising psychotherapists. Finally, as Reeve (2002) discusses, there is a risk in further differentiating disabled individuals from nondisabled individuals by creating a "special" type of therapy. As Shakespeare (1996) mentions, persons with disabilities as multifaceted individuals identify not only as disabled individuals, but also through gender, race, religion, sexual identity, etc.

### *Summary*

In summary, I argue that each history and definition of disability has both enhanced the lives of and added to the oppression of individuals with disabilities. Further, each model cannot be used on its own to define the disabled community. Rather, I argue it is through abstracting the positive aspects of each definition and critically evaluating the more negative aspects that we can gain a more comprehensive understanding of this complex group of individuals. Also, each definition can be used to enhance the personal lives of people with disabilities in psychotherapy. This is the goal of disability-affirmation: to acknowledge the need for multiple understandings of disability, respecting the client's need to find his or her own model, and moulding therapy to match the client's understanding of disability (Olkin, 2001). However, disability must be seen as having some value in order for a therapist to truly appreciate and help clients with disabilities (Shakespeare, 1996). Your clients may hate their disabilities, and it will be important for you to acknowledge that they are within their rights to hate their disabilities, but you still need to acknowledge that your clients are capable of being productive and happy, and this requires a positive perception of disability. Further, for the clients who hate their disabilities, a goal of therapy under the disability-affirmative model will be for them to come to see their disabilities in a more positive way in an effort for them to accept themselves (Reeve, 2002).

### Conclusions

Throughout this paper, I have argued that change is needed in the psychotherapy community in terms of how we understand and conceptualize disability. There still exists a great deal of oppression in the counselling room, and research indicates that therapists tend to view disability as a personal tragedy (Parkinson, 2006). Furthermore, there is no way of knowing how effective traditional psychotherapy services have been for persons with disabilities as little research has even broached the subject. However, theoretically, psychotherapy research and services have great potential for helping individuals with disabilities reach their full human potential (e.g., Rogers, 1957). Perhaps psychotherapy can be used as a tool to help individuals understand themselves according to whichever way they choose to define disability, and deal with the external reality of being an oppressed minority group in a society that often does not accommodate them (Shakespeare, 1996). On the same note, psychotherapy services and research have the possibility to further oppress and victimize these individuals (Lawthorn, 2005). As qualitative research has revealed, both these realities are operating today in psychotherapy. It is my hope that through adopting a disability-affirmative model, therapists and clients can learn to accept disability as something both valued and challenging.

In Sutherland's book *Disabled We Stand* (1981), the author discusses how the disability community can never reach true equality unless the idea of being disabled versus normal is eliminated. He argues:

A more radical approach is needed: we must demolish the false dividing line between 'normal' and 'disabled' and attack the whole concept of physical normality. We have to recognize that disablement is not merely the physical state of a small minority of people. It is the normal condition of humanity (Sutherland, 1981, p. 18).

Although I agree that viewing disability as an impairment or less than normal is the main issue, I question the practicality of the author's agenda. Disability brings up thoughts of worthlessness in society and the minds of those who inhabit that society (Shakespeare, 1999). Oppression still exists and the social reality of persons with disabilities is less than ideal. In a society that values dualistic thinking, I believe that keeping that minority status may be the best solution at this time. A quote by Helen Keller summarizes this issue coherently: "Science may have found a cure for most evils; but it has found no remedy for the worst of them all—the apathy of human beings". Although she was quoted saying this over 50 years ago, it is as true today as it was then.

However, I do believe that small changes are possible, especially within the field of psychotherapy where qualities like empathy and human potential are valued (Rogers, 1957). In order to get over this societal standard of apathy, I believe individuals in the field of psychotherapy must actively challenge their own basic assumptions about disability and take on this disability-affirmative model to shape their views, behaviours, and feelings when working with disability. The benefits of this model are such that it is flexible and positive.

Disability is part of the human condition. It can be, or contribute to, a medical occurrence. It is also a minority status. Further, it is a rich and valued culture. Until individuals can incorporate and truly emulate this complex combination of social, individualistic, medical, spiritual, and cultural ideals, persons with disabilities will continue to feel misunderstood and marginalized when seeking psychotherapy services. Furthermore, to incorporate this understanding of disability, the first step is for Psychology

to actually begin discussing disability in the first place. Over 14 million Canadians should not, and cannot, be dismissed from a field as influential as Psychology and mental health services. There has been some research and literature bridging the gap between Critical Disability Studies and Psychology, and it is hoped that these studies will grow in the future. The benefits of persons with disabilities in using a more disability-affirmative psychotherapy service will only be shadowed by the benefits the field of psychotherapy will receive by involving innovative ideas and research from this rich and diverse group of individuals in the disability community.

#### References

- Barnes, C., Mercer, G., & Shakespeare, T. (1999). *Exploring disability: A sociological introduction*. Cambridge: Polity Press.
- Beckett, C., & Wrighton, E. (2000). "What matters to me is not what you're talking about": Maintaining the social model of disability in "public and private" negotiations. *Disability and Society*, 15, 991–999.
- Corker, M. (1995). *Counselling: The deaf challenge*. London: Jessica Kingsley.
- Crow, L. (1996) Including all our lives: renewing the social model of disability. In C. Barnes, & G. Mercer (Eds.), *Exploring the divide: illness and disability* (pp. 55–72). Leeds: The Disability Press.
- Dewsbury, G., Clarke, K., Randall, D., Rouncefield, M., & Sommerville, I. (2004). The anti-social model of disability. *Disability & Society*, 19, 145-158.
- Erevelles, N. (1997, March). Re-constituting the disabled other: Historical materialism and the politics of schooling. Paper presented at the Annual Meeting of the American Education Research Association. Chicago, IL.
- Finkelstein, V., & French, S. (1993). Towards a psychology of disability. In J. Swain, V. Finkelstein, S. French, & M. Oliver (Eds.), *Disabling barriers – enabling environments*. London: Sage.

- Fow, N. R. (1998). Supportive psychotherapy and psychological adjustment to physical disability. *Journal of Applied Rehabilitation Counseling, 29*, 20–24.
- Freud, S. (1920). *A general introduction to psychoanalysis*. Transl. S. Hall. New York, NY: Horace Liveright.
- Galvin, R. (2003). The paradox of disability culture: The need to combine versus the imperative to let go. *Disability & Society, 18*, 675–690.
- Goodley, D., & Lawthom, R. (2005). Epistemological journeys in participatory action research: Alliances between community psychology and disability studies. *Disability & Society, 20*, 135–151.
- Linton, J. M., & Daugherty, T. K. (1999). Perceived therapeutic qualities of counselor trainees with disabilities. *Journal of Instructional Psychology, 26*, 30–35.
- Livneh, H. (1986). A unified approach to existing models of adaptation to disability: Part I- a model of adaptation. In S. Robertson & R. Brown (Eds.), *Rehabilitation Counseling: Approaches in the field of disability*. London: Chapman & Hall.
- Lonsdale, S. (1990). *Women and disability: The experience of physical disability among women*. New York: St. Martin's Press.
- Mancin, D.J., Stecklov, G., & Stewart, J. F. (2003). Cost of lost productive work time among US workers with depression. *JAMA: Journal of the American Medical Association, 289*, 3135–3144.
- McKenzie, A. (1992). Counseling for people disabled through injury. *Social Care Research Findings, 19*. York: Joseph Rowntree Foundation.
- Neisser, U. (1967). *Cognitive Psychology*. New York: Appleton Crofts.
- Oliver, M. (1996). *Understanding disability: From theory to practice*. Basingstoke: Palgrave Press.
- Olkin, R. (2001). *What psychologists should know about disability*. New York, NY: Guilford Press.
- Pakenham, K. I. (2008). Making sense of illness or disability. *Journal of Health Psychology, 13*, 93–105.
- Parkinson, G. (2006). Counselors' attitudes towards disability equality training (DET). *British Journal of Guidance & Counseling, 34*, 93–105.



- Patston, P. (2007a). Constructive functional disability: A new paradigm beyond disability and impairment. *Disability & Rehabilitation*, 29, 1625–1633.
- Patston P. (2007b). *Making it Easy to Do the Right Thing*. Wellington, New Zealand: Health and Disability Commissioner.
- Reeve, D. (2002). Oppression within the counseling room. *Counseling and Psychotherapy Research*, 2, 11–19.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Romanach, J., & Lobarto, M. (2005). Functional diversity, a new term in the struggle for dignity and diversity of the human being. *Independent Living Forum*. Retrieved February 28, 2009, from: [http://www.leeds.ac.uk/disability-studies/archiveuk/zavier/Functional%20Diversity%20%20%20%20%20%20%20%20%20%20%20\\_fv%20Roma%F1ach.pdf](http://www.leeds.ac.uk/disability-studies/archiveuk/zavier/Functional%20Diversity%20%20%20%20%20%20%20%20%20%20%20_fv%20Roma%F1ach.pdf).
- Shakespeare, T. (1996). Disability, identity, difference. In C. Barnes and G. Mercer (Eds.), *Exploring the Divide: Illness and Disability* (pp. 94–113). Leeds: Disability Press.
- Shakespeare, T. (1999). What is a disabled person? In M. Jones, & L. A. Basser Marks (Eds.), *Disability, divers-ability and legal change* (pp. 25–35). The Hague, Netherlands: Kluwer Law.
- Shakespeare, T. (2008). Disability: Suffering, social oppression or complex predicament? In *The Contingent Nature of Life*. Netherlands: Springer.
- Sutherland A. (1981). *Disabled we stand*. London: Souvenir Press.
- Swain, J., & French, S. (2000). Towards an affirmative model of disability. *Disability and Society*, 15, 569–582.
- World Health Organization (2001). *International Classification of Functioning, Disability and Health*. Geneva: World Health Organization. Retrieved October 25, 2009, from <http://www.who.int/classifications/icf/en/>.
- Yohannes, A.M., Koenig, H.G., Baldwin, R.C., & Connolly, M.J. (2008). Health behavior, depression and religiosity in older patients admitted to intermediate care. *International Journal of Geriatric Psychiatry*, 23, 735–740.